STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G141	A. BUILDING 02 B. WING	09/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUTNAM COUNTY COMPREHENSIVE SERVICES INC	914 TENNESSEE ST GREENCASTLE, IN46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 09/12/11 Facility Number: 000678 Provider Number: 15G141 AIM Number: 100234430 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Putnam County Comprehensive Services Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was fully sprinklered. The facility has a fire alarm system with smoke	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	detection in corridors, resident rooms and common living areas. The facility has the capacity for 6 and had a census of 6 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.3. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/14/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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KS053	Approved smoke alarms are provided in accordance with 9.6.2.10. These alarms are powered from the building electrical system and when activated, initiate an alarm that is audible in all sleeping areas. Smoke alarms are installed on all levels, including basements but excluding crawl spaces and unfinished attics. Additional smoke alarms are installed for living rooms, dens, day rooms, and similar spaces. 33.2.3.4.3. Exception No 1: Buildings protected throughout by an approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system. Exception No. 2: Where buildings are protected throughout by an approved automatic sprinkler system, in accordance with 32.3.2.5, that uses quick-response or residential sprinklers, with existing battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms. Based on record review and interview, the facility failed to provide evidence 4 of 10 smoke detectors were tested by a qualified service technician to ensure they were within their listed and marked sensitivity range. LSC 9.6.2.10 requires	KS053	B&R was contacted immediately upon the realization that 4 smoke detectors were missed during their recent testing by a qualified technician to ensure all the detectors were with the acceptable range. They returned to facility on 9-13-11 to complete the testing on the 4 overlooked detectors. All 4 of the previously missed detectors passed the test.	09/13/2011

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	smoke alarms shall be in accordance with the requirements of NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3 requires testing to be in accordance Section 7-3, Inspection and Testing Frequencies. NFPA 72, 7-3.2.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method. (2) Manufacturer's calibrated		In order to prevent this from occuring in the future we have included the location of all smoke detectors on our evacuation plan for easy identification. The agency Quality Assurance Director has also been provided with a copy of smoke detector locations. upon completion of future detector testing the House Manager will review the results with the Quality Assurance Director to ensure the report includes all 10 smoke detectors and that all dectectors have passed the required test.	

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	sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device administering an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2.2 requires a permanent record of all inspections, testing and maintenance shall be provided. This deficient practice affects all clients, staff and visitors. Findings include: Based on a review of records provided with the house manager on 09/12/11 at 1:55 p.m., documentation of smoke detector			

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	sensitivity testing was incomplete. The Smoke Detector Test Report dated 09/01/11 listed six of the ten smoke detectors in the house. The list noted two bedroom detectors and "Hallway". There are three bedrooms and three detectors which could have been included in the hallway. There was no information for which bedroom detectors were included in the test and which hallway smoke detectors; only one sensitivity test result was noted for each entry. The office smoke detector was not included in the test information. There were no other records of sensitivity testing which included these missing devices. The house manager said at the time of record review, she had not noticed all detectors were not included in the documentation.			

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KS147	The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1 Based on record review and interview, the facility administration failed to ensure all employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan for special staff response, including fire protection procedures needed to ensure the safety of 6 of 6 clients, which is amended or revised whenever any resident with unusual needs is admitted to the home. Such instruction is reviewed by the staff at least every two months. This deficient practice could affect all clients.	KS147	Residential Director reviewed policy and procedures with Management staff, identifying areas in need of revision. Updates are being made after which we will begin training staff. All residents are assessed at least annually and currently two individuals have been identified as potentially needing additional protections during evacuations. Procedures have been updated to reflect those needs. All fire drills have been scheduled for the next 15 months and are posted on the communication board for staff. Management is to immediately review all drills for accuracy and potential problems as well as timeliness. After completing any required follow-up the completed drill is to be submitted to the	09/30/2011

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	Findings include: Based on Fire Drill Rosters reviewed with the house manager on 09/12/11 at 2:00 p.m., a lapse in staff fire safety training time was more than the two months allowed as evidenced by the lack of any fire drill record for the 6:00 a.m. to 3:00 p.m. shift during the fourth quarter of 2010 and the 10:00 p.m. to 6:00 a.m. shift during the third quarter of 2010. Drills were not found for the 10:00 p.m. to 6:00 a.m. shift for the second quarter of 2011. The house manager said at the time of record review, fire drill documentation was not available for these periods. As a result, there was a lapse of five months between the July 2010 and January 2011 fire drills conducted on the second shift, and May of 2010 and November 2010 for the third shift. A lapse of five months for the third shift fire drills for 2011 to date since the last one was documented in March 2011. The house manager said at the time of record review, there were no records for when the staff on		Quality Assurance Director for further review. Staff will complete fire safety training at their monthly staff meetings and it will be documented, the next meeting is 9/30/11 and monthly thereafter. Residential Director met with House Manager and issued a verbal waring regarding the importance of ensuring the timeliness of drills. It was agreed that disciplinary action would follow immediately any staff failing to complete assigned drills. Repeat failures could results in termination.	

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	these shifts completed any other fire safety/evacuation training during the periods noted.			
KS152	(1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. (2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. (3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. Based on record review and interview, the facility failed to ensure fire and evacuation drills were provided for each shift for 2	KS152	All fire drills have been scheduled for the next 15 months and are posted on the communication board for staff. Management is to immediately review all drills for accuracy and potential problems	09/30/2011

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	of 4 quarters. This deficient practice affects all occupants. Findings include: Based on Fire Drill Rosters reviewed with the house manager on 09/12/11 at 2:00 p.m., a lapse in staff fire safety training was evidenced by the lack of any fire drill record for the 6:00 a.m. to 3:00 p.m. shift during the fourth quarter of 2010 and the 10:00 p.m. to 6:00 a.m. shift during the third quarter of 2010. Drills were not found for the 10:00 p.m. to 6:00 a.m. shift for the second quarter of 2011. The house manager said at the time of record review, there was no fire drill documentation available for these periods.		as well as timeliness. After completing any required follow-up the completed drill is to be submitted to the Quality Assurance Director for further review. The Quality Assurance Director has been provided with a copy of the drill schedule to further assure timeliness. Staff will complete fire safety training 9/30/11 where a drill will be conducted. Residential Director met with House Manager and issued a verbal warning regarding the importance of ensuring the timeliness of drills. It was agreed that disciplinary action would follow immediately any staff failing to complete assigned drills. Repeat failures could results in termination.	